STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaints IN00106034 and IN00104084. Complaint IN00106034 - Substantiated. State deficiencies related to the allegation are cited at R052 and R091. Complaint IN00104084 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 10, 11, 12 & 13, 2012 Facility number: 012263 Provider number: 012263 AIM number: N/A Survey team: Christi Davidson, RN-TC Census bed type: Residential: 105 Total: 105 Census payor type: Other: 105 Total: 105 Residential sample: 5	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These state findings are cited in accordance with 410 IAC 16.2. Quality review 4/17/12 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from physical abuse and neglect, related to the failure to ensure an allegation of abuse was immediately reported to the Administrator, for 1 of 5 residents sampled. The allegation went uninvestigated, the employee who allegedly pushed a resident causing her to fall was not removed from the facility pending investigation, and the potential for abuse remained for the 32 residents in the memory care unit. (#H) Findings include: The record of Resident #H was reviewed on 4/13/12 at 10:00 a.m. Diagnoses included, but were not limited to, degenerative joint disease of the left hip, dementia, hypertension, depression, anxiety, and insomnia. The most current service plan dated	R0052	1. As soon as the incident was reported to the Administrator on 4/12/12 our policies and procedures were followed. During the investigation on 4/12/12 into the incident on 3/7/12 it came to the Administrator's attention that a resident was allegedly pushed to the ground by an LPN. During the investigation period Employee #1 and Employee #2 were suspended. The Administrator and Business Office Manager conducted interviews with 6 employees that were present for the evening in question: March 7, 2012. The investigation concluded with differing eye witness accounts and no physical proof of abuse by any employees. Both employees were reinstated to full time work status. 2. The Administrator interviewed other employees and residents that were in the community on the evening of March 7, 2012. No other incidents were reported as suspicious. 3. On 4/20/12 the Administrator conducted an abuse in-service for all staff members. The in-service attendance sheet is submitted as	04/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/24/12 indicated the resident ambulated independently with a rolling walker and was independent with transfers, dressing, toileting and personal hygiene. The service plan indicated, "...Requires assistance with bathing. Special requirements for bathing repeated encouragement to bathe. Difficult to bathe requires case manager to give bathes (sic) often D/T [due to] resident gets aggressive with staff when approached for baths...Judgement and memory are generally good. Needs monitoring and guidance...." The most current Fall Risk Evaluation dated 2/24/12 indicated Resident #H was a medium fall risk. The evaluation indicated the resident was disoriented x 1, had 1-2 falls in the past 3 months, had balance problems while standing/walking and took 3-4 medications in the categories listed which could increase the risk of falls. A nurses note dated 3/7/12 at 7:15 p.m. indicated, "Res [resident] refused to put clothes on after shower. Staff exited Res room to allow Res time to de-escalate...Res came out into hallway naked. Staff attempted to redirect Res into room. Res began screaming and hitting at staff...Staff left Res alone to de-escalate. Res began following staff		appendix A. This in-service included clear definitions of our abuse policy, appendix B. Special focus was put on the courage that it may take for friends and co-workers to report other friends and co-workers if abuse is suspected. All employees took a post test, appendix C, including true/false questions and a specific question regarding who they would report abuse to. The answers to the test were reviewed during the in-service. It is clear to all employees that suspected abuse is to be immediately reported to the Administrator. The Administrator's name and phone number was placed in highly visible areas around the community for employees to report abuse appropriately. 4. The Administrator will conduct sample interviews of 2 staff members monthly specifically asking for any unreported or questionable incidents. All directors will reassure employees of their open door for communication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	into other Res rooms swearing and striking out...Family [and] management [and] MD [medical doctor] notified." A nurses note dated 3/7/12 at 7:40 p.m. indicated, "Res out in hallway naked carring (sic) towel [and] swinging it over her head...." A nurses note dated 3/7/12 at 7:50 p.m. indicated, "Res again came out of room and followed staff member...Res pushed res room door open and as staff turned around struck staff in the face...Res continued screaming and throwing self at walls and doors...." A nurses note dated 3/7/12 at 8:00 p.m. indicated, "Res came to nursing station, picked up walker and hit door screaming at staff...." A nurses note dated 3/7/12 at 8:10 p.m. indicated, "...This writer contacted EMS [emergency medical system] to transport Res to ER [emergency room] for eval [evaluation]...Res would not allow this writer to assess skin at this time." A nurses note dated 3/7/12 at 8:20 p.m. indicated, "EMS arrived to transport Res...." The record lacked documentation of any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	injury to Resident #H on 3/7/12. During an interview on 4/12/12 at 11:45 a.m., LPN [Licensed Practical Nurse] #6 indicated a CNA [Certified Nursing Assistant] witnessed a staff member push down a resident. She indicated the incident involved Resident #H and the CNA who witnessed the alleged abuse was CNA #2. During an interview on 4/12/12 at 12:28 p.m., CNA #5 indicated Resident #H had pulled her braid out when the resident was combative. She indicated CNA #2 was assisting her in giving Resident #H a shower when the resident was "upset." CNA #5 indicated the resident "went for [name of CNA #2]" and indicated CNA #2's ear, from what she thought was an earring, started bleeding. During an interview on 4/12/12 at 2:20 p.m., CNA #2 indicated on an evening shift in the memory care unit early in March 2012, there was an incident with Resident #H. CNA #2 indicated she and 3 other CNAs were assisting resident #H with a shower. After the shower, CNA #2 indicated the resident "got mad" when they were helping to dry off the resident. The CNA indicated Resident #H pinned herself in the shower. CNA #2 indicated the CNAs dried the floor, laid out the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's clothes and left the resident. CNA #2 indicated the resident came out of her room without clothes on and chased the CNAs. CNA #2 indicated they attempted to re-direct the resident. CNA #2 indicated QMA [Qualified Medication Aide] #4 came out to help. The resident could not be re-directed and LPN #3 came to assist. CNA #2 indicated the four CNAs paired off 2 and 2 to continue giving resident care to the other residents in the memory care unit while QMA #4 and LPN #3 continued to care for Resident #H. CNA #2 indicated while her and another CNA were giving care to a different resident in the resident's room, Resident #H came in and pulled out a braid extension from that CNA's hair and hit CNA #2 in the ear causing it to bleed. CNA #2 indicated LPN #3 and QMA #4 took Resident #H back toward her room. CNA #2 indicated she witnessed LPN #3 walk behind the resident and push the resident into her room causing the resident to fall and knock into TV trays in the room. CNA #2 stated, "[Name of LPN # 3] turned and said, 'she fell, right?' and then left the resident." CNA #2 indicated QMA #4 had left the resident to call 911. CNA #2 indicated she was the only witness. CNA #2 indicated she watched at the doorway and saw the resident get up. CNA #2 indicated she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	went to get another CNA to help her assist the resident to get dressed as the resident remained naked. CNA #2 indicated when she returned with another CNA, Resident #H was "calm and sweet." The CNA indicated Resident #H could not remember what happened. CNA #2 indicated the ambulance came and transported Resident #H out of the facility. CNA #2 indicated she did not report the incident to the administrator, the director of the memory care unit, or the director of nursing because she was afraid of LPN #3 and was afraid of reporting to administration. CNA #2 indicated she was aware of facility policy. She indicated she was supposed to report to the nurse. She indicated she learned about recognizing and reporting abuse in her CNA classes. During an interview on 4/12/12 at 3:30 p.m., the Administrator indicated he was not aware of the abuse allegation involving LPN #3. The Administrator indicated he was aware Resident #H had escalated behaviors and was sent out by LPN #3 by 911 call to have a psychiatric evaluation on 3/7/12. The Administrator indicated staff interviews had been conducted concerning the resident's behaviors and staff reaction and was not aware of the allegation of LPN #3 pushing and causing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #H to fall during the episode. The Administrator indicated he would report the allegation to the state agency, immediately remove LPN #3 from duty and begin an investigation. The Administrator indicated he was not aware that at least one employee was afraid to report an allegation of abuse. During an observation on 4/13/12 at 11:15 a.m., Resident #H's room was observed to be in the middle of a hallway away from the main activity room and dining room. The memory care unit is designed in a square. On 4/13/12 at 12:15 p.m., the Administrator provided an employee sign-in sheet related to the abuse prevention in-service dated 3/16/12 at 2:30 p.m. On 4/10/12 at 10:45 a.m., the Administrator provided the Abuse Policy dated 9/27/11 and indicated this policy was the most current. The policy indicated, "...Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator. Confirmed abuse/neglect will be reported to the State Department of Health within 24 hours of the occurrence...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/10/12 at 11:00 a.m., the Administrator indicated that all allegations of abuse or neglect must be reported to the state agency. On 4/11/12 at 3:05 p.m., the Administrator provided the most recent Abuse Prevention Addendum dated 4/11/12. The Abuse Prevention Addendum indicated, "...Prevention of abuse training will be provided upon hiring and annual thereafter...Employees' main responsibility is to proved (sic) immediate safety if there is a potential of abuse or harm to a resident...Employees will report all situations that may be considered abuse or neglect to a resident from any and all sources. Retaliation to residents, employees or others who report suspected abuse or neglect is not permitted. Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator...." This state finding relates to complaint IN00106034.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview and record review, the facility failed to ensure policies and procedures for abuse reporting were implemented. An allegation of abuse was not reported to the Administrator for 1 of 5 residents reviewed for abuse in the sample of 5. (#H) Findings include: The record of Resident #H was reviewed on 4/13/12 at 10:00 a.m. Diagnoses included, but were not limited to, degenerative joint disease of the left hip, dementia, hypertension, depression, anxiety, and insomnia. The most current service plan dated 2/24/12, indicated the resident ambulated independently with a rolling walker and was independent with transfers, dressing,	R0091	1. On 4/12/12 the Administrator interviewed 6 staff members involved in the incident on March 7, 2012. During the interview Employee #1 gave an account of suspected abuse. Employee #1, as well as the accused Employee #2, were both suspended pending investigation. At the conclusion of the investigation, Employee #1 was counseled on proper reporting procedure. It was made clear to Employee #1 that timeliness of reporting is just as important as reporting abuse in the first place. Employee #1 then signed an abuse policy acknowledgement form. 2. The Administrator interviewed other employees and residents that were in the community on the evening of March 7, 2012. No other incidents were reported as suspicious. 3. On 4/20/12 the Administrator conducted an abuse in-service for all staff members. The in-service attendance sheet is submitted as appendix A. This in-service	04/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	toileting and personal hygiene. The service plan indicated, "...Requires assistance with bathing. Special requirements for bathing - repeated encouragement to bathe. Difficult to bathe, requires case manager to give bathes (sic) often D/T [due to] resident gets aggressive with staff when approached for baths...Judgement and memory are generally good. Needs monitoring and guidance...." The most current Fall Risk Evaluation dated 2/24/12, indicated Resident #H was a medium fall risk. The evaluation indicated the resident was disoriented x 1, had 1-2 falls in the past 3 months, had balance problems while standing/walking and took 3-4 medications in the categories listed which could increase the risk of falls. A nurses note dated 3/7/12 at 7:15 p.m. indicated, "Res [resident] refused to put clothes on after shower. Staff exited Res room to allow Res time to de-escalate...Res came out into hallway naked. Staff attempted to redirect Res into room. Res began screaming and hitting at staff...Staff left Res alone to de-escalate. Res began following staff into other Res rooms swearing and striking out...Family [and] management [and] MD [Medical Doctor] notified."		included clear definitions of our abuse policy, appendix B. Special focus was put on the courage that it may take for friends and co-workers to report other friends and co-workers if abuse is suspected. All employees took a post test, appendix C, including true/false questions and a specific question regarding who they would report abuse to. The answers to the test were reviewed during the in-service. It is clear to all employees that suspected abuse is to be immediately reported to the Administrator. The Administrator's name and phone number was placed in highly visible areas around the community for employees to report abuse appropriately. 4. The Administrator will conduct sample interviews of 2 staff members monthly specifically asking for any unreported or questionable incidents. All directors will reassure employees of their open door for communication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A nurses note dated 3/7/12 at 7:40 p.m. indicated, "Res out in hallway naked carring (sic)towel [and] swinging it over her head...."

A nurses note dated 3/7/12 at 7:50 p.m. indicated, "Res again came out of room and followed staff member...Res pushed res room door open and as staff turned around struck staff in the face...Res continued screaming and throwing self at walls and doors...."

A nurses note dated 3/7/12 at 8:00 p.m. indicated, "Res came to nursing station, picked up walker and hit door screaming at staff...."

A nurses note dated 3/7/12 at 8:10 p.m. indicated, "...This writer contacted EMS [emergency medical system] to transport Res to ER [emergency room] for eval [evaluation]...Res would not allow this writer to assess skin at this time."

A nurses note dated 3/7/12 at 8:20 p.m. indicated, "EMS arrived to transport Res...."

The record lacked documentation of any injury to Resident #H on 3/7/12.

During an interview on 4/12/12 at 11:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m., LPN [Licensed Practical Nurse] #6 indicated a CNA [Certified Nursing Assistant] witnessed a staff member push down a resident. She indicated the incident involved Resident #H and the CNA who witnessed the alleged abuse was CNA #2. During an interview on 4/12/12 at 12:28 p.m., CNA #5 indicated Resident #H had pulled her braid out when the resident was combative. She indicated CNA #2 was assisting her in giving Resident #H a shower when the resident was "upset." CNA #5 indicated the resident "went for [name of CNA #2]" and indicated CNA #2's ear, from what she thought was an earring, started bleeding. During an interview on 4/12/12 at 2:20 p.m., CNA #2 indicated on an evening shift in the memory care unit early in March 2012, there was an incident with Resident #H. CNA #2 indicated she and 3 other CNAs were assisting resident #H with a shower. After the shower, CNA #2 indicated the resident "got mad" when they were helping to dry off the resident. The CNA indicated Resident #H pinned herself in the shower. CNA #2 indicated the CNAs dried the floor, laid out the resident's clothes and left the resident. CNA #2 indicated the resident came out of her room without clothes on and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chased the CNAs. CNA #2 indicated they attempted to re-direct the resident. CNA #2 indicated Qualified Medication Aide [QMA] #4 came out to help. The resident could not be re-directed and LPN #3 came to assist. CNA #2 indicated the four CNAs paired off 2 and 2 to continue giving resident care to the other residents in the memory care unit while QMA #4 and LPN #3 continued to care for Resident #H. CNA #2 indicated while her and another CNA were giving care to a different resident in the resident's room, Resident #H came in and pulled out a braid extension from that CNA's hair and hit CNA #2 in the ear causing it to bleed. CNA #2 indicated LPN #3 and QMA #4 took Resident #H back toward her room. CNA #2 indicated she witnessed LPN #3 walk behind the resident and push the resident into her room causing the resident to fall and knock into TV trays in the room. CNA #2 stated, "[Name of LPN # 3] turned and said, 'she fell, right?' and then left the resident." CNA #2 indicated QMA #4 had left the resident to call 911. CNA #2 indicated she was the only witness. CNA #2 indicated she watched at the doorway and saw the resident get up. CNA #2 indicated she went to get another CNA to help her assist the resident to get dressed as the resident remained naked. CNA #2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated when she returned with another CNA, Resident #H was "calm and sweet." The CNA indicated Resident #H could not remember what happened. CNA #2 indicated the ambulance came and transported Resident #H out of the facility. CNA #2 indicated she did not report the incident to the administrator, the director of the memory care unit, or the director of nursing because she was afraid of LPN #3 and was afraid of reporting to administration. CNA #2 indicated she was aware of facility policy. She indicated she was supposed to report to the nurse. She indicated she learned about recognizing and reporting abuse in her CNA classes. During an interview on 4/12/12 at 3:30 p.m., the Administrator indicated he was not aware of the abuse allegation involving LPN #3. The Administrator indicated he was aware Resident #H had escalated behaviors and was sent out by LPN #3 by 911 call to have a psychiatric evaluation on 3/7/12. The Administrator indicated staff interviews had been conducted concerning the resident's behaviors and staff reaction and was not aware of the allegation of LPN #3 pushing and causing Resident #H to fall during the episode. The Administrator indicated he would report the allegation to the state agency,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately remove LPN #3 from duty and begin an investigation. The Administrator indicated he was not aware that at least one employee was afraid to report an allegation of abuse. During an observation on 4/13/12 at 11:15 a.m., Resident #H's room was observed to be in the middle of a hallway away from the main activity room and dining room. The memory care unit is designed in a square. On 4/13/12 at 12:15 p.m., the Administrator provided an employee sign-in sheet related to the abuse prevention in-service dated 3/16/12 at 2:30 p.m. On 4/10/12 at 10:45 a.m., the Administrator provided the Abuse Policy dated 9/27/11 and indicated this policy was the most current. The policy indicated, "...Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator. Confirmed abuse/neglect will be reported to the State Department of Health within 24 hours of the occurrence...." During an interview on 4/10/12 at 11:00 a.m., the Administrator indicated that all allegations of abuse or neglect must be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reported to the state agency. On 4/11/12 at 3:05 p.m., the Administrator provided the most recent Abuse Prevention Addendum with a review date of 4/11/12. The Abuse Prevention Addendum indicated, "...Prevention of abuse training will be provided upon hiring and annual thereafter...Employees' main responsibility is to proved (sic) immediate safety if there is a potential of abuse or harm to a resident...Employees will report all situations that may be considered abuse or neglect to a resident from any and all sources. Retaliation to residents, employees or others who report suspected abuse or neglect is not permitted. Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator...." This state finding relates to complaint IN00106034.			